STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345211	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverpoint Crest Nursing and Rehabilitation Center	2600 Old Cherry Point Road New Bern, NC 28563

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews the facility failed to treat 1 of 3 residents in a respectful and dignified manner when Resident #66 was seated in his geriatric wheelchair (a special medical recliner with a wheeled base designed for older adults and individuals with mobility issues) as Occupational Therapist #1 pulled the wheelchair down the hall with the resident positioned behind her resulting in the resident being unable to see where he was being taken to. A reasonable person has the expectation of being treated with dignity and would not want to be moved via wheelchair in a backwards motion with no ability to view where they are traveling. Findings included: Resident #66 was admitted to the facility on [DATE]. A physician's order written on 08/28/25 revealed an order for Occupational Therapy (OT) to evaluate and treat as indicated. Resident #66's Minimum Data Set 5-day assessment dated [DATE] revealed he was severely cognitively impaired. An observation of Resident #66 on 09/15/25 at 11:10 AM revealed the resident was seated in his geriatric wheelchair while Occupational Therapist #1 (OT) pulled the wheelchair down the hall with the resident positioned behind her resulting in the resident being unable to see where he was being taken to by OT #1. An interview was conducted with OT #1 on 09/15/25 at 11:10 AM. OT #1 stated she was not aware that pulling a resident behind her was a dignity issue and that she was pulling the chair because it was difficult to push. OT #1 turned Resident #66's chair around and proceeded down the hall while she pushed the resident in front of her. An interview was conducted with the Rehabilitation Manager on 09/17/25 at 2:45 PM. The Rehabilitation Manager stated that OT #1 was an agency therapist, and that all staff including agency staff had been in-serviced according to the training for this facility to include treating residents with dignity and respect. She stated just recently the therapy staff were all sub-contracted, but now there was new therapy staff, and they were employed by the facility and the training that was required for this facility was given to the therapists. The Rehabilitation Manager stated OT #1 should have known that pulling a resident from behind while the resident was sitting in a mobility device was a dignity issue. She stated she would make sure further education was provided. An interview was conducted with the Director of Nursing (DON) on 09/17/25 at 3:00 PM. The DON stated she had some new staff in the therapy department, but that she would have expected for the therapy staff to know that pulling a resident behind them as they walked down a hall was a dignity concern and she would be sure education was done to reinforce this dignity issue.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and Resident Representative (RR) interviews, the facility failed to facilitate the inclusion of the RR of a severely cognitively impaired resident in the care planning process for 1 of 2 residents reviewed for the care planning process (Resident #71). Findings included: Resident #71 was admitted to the facility on [DATE]. The most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #71 was severely cognitively impaired. The medical record indicated Resident #71's family member was her Resident Representative (RR). A review of the care plan for Resident #71 indicated it was last revised on 8/18/25. Record review for Resident #71 revealed there were no care plan meetings documented nor was there documentation of attempts to contact or conversations with the RR since admission. On 9/17/25 at 9:50 AM a telephone interview with Resident #71's RR revealed he did not recall being invited to a care plan meeting. Resident #71's RR stated he would like to be invited to attend care plan meetings. In an interview with the Administrator on 9/17/25 at 9:50 AM she stated the facility had last employed a Social Worker (SW) from January to June of 2025 and she was responsible for invitations to care plan meetings during that time. The Administrator indicated she had been responsible for sending care plan meeting invitations to residents or their RR's since June 2025 but could not locate documentation regarding sending an invitation to Resident #71's RR. The previous SW was unavailable for interview.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and resident interviews, the facility failed to assess the ability of a resident to self-administer medications (chewable antacid tablets, cough drops, topical arthritis cream with 25% capsaicin and topical arthritis pain relief gel with 2% menthol) that were kept at the bedside for 1 of 1 resident reviewed for self-administration of medications (Resident #19). Findings included: Resident #19 was admitted to the facility on [DATE] with diagnoses that included non-Alzheimer's dementia and chronic pain syndrome. Review of Resident #19's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated she was moderately cognitively impaired. Review of Resident #19's physician orders revealed no order to self-administer medications, no order for arthritis pain relief cream with capsaicin, arthritis pain relief gel with menthol, cough drops or chewable antacid tablets were noted. Review of Resident #19's medical record revealed no documentation Resident #19 was assessed for self-administration of medications. Review of Resident #19's care plan last revised 9/15/25 did not reveal a care plan related to self-administration of medications. In an observation and interview with Resident #19 on 9/15/25 at 1:24 PM the resident stated she had chronic pain and had a Nurse or Nurse Aide (NA) put arthritis cream on her knees that morning. Resident #19 proceeded to open the second drawer of her bedside table to show that she kept arthritis cream with 25% capsaicin and arthritis pain relief gel with 2% menthol in the drawer for ease of use throughout the day. Resident #19 further stated she applied the arthritis cream or gel herself throughout the day. A 12-ounce paper cup was observed in the drawer that held what appeared to be loose chewable antacid tablets and individually wrapped cough drops. Resident #19 indicated she used chewable antacid tablets when she had an upset stomach and the cough drops were used for an occasional scratchy throat. A second observation and interview were conducted on 9/16/25 at 8:06 AM with Resident #19. A tube of arthritis cream with 25% capsaicin was sitting on top of the bedside table. Resident #19 indicated she still had the arthritis gel, chewable antacid tablets and cough drops in her bedside table. Resident #19 opened the second drawer of the bedside table where the items were observed to still be there. In an interview with Nurse #1 on 9/16/25 at 10:25 AM she stated she was unaware Resident #19 kept any medications at her bedside and was unsure if the resident had been assessed for self-administration of medications. Nurse #1 further stated she had applied arthritis cream to Resident #19's knees but the cream had come from the medication cart. In an interview with the Unit Manager (UM) on 9/16/25 at 10:36 AM she stated she was unaware Resident #19 had medications at the bedside. She further stated she was unaware of how a resident would have been assessed for self-administration of medications. An interview was conducted with NA #6 on 9/16/25 at 10:40 AM. NA #6 stated had not put arthritis cream or gel on Resident #19 at any time. An interview was conducted with the Director of Nursing (DON) on 9/16/25 at 10:48 AM she indicated she was unaware Resident #19 kept medications in her bedside table. The DON stated Resident #19 had not been assessed for self-administration of medications. An interview was conducted with the Administrator on 9/15/25 at 2:40 PM. She stated she was unaware Resident #19 kept medications at the bedside and was unsure how the facility would have known that Resident #19 had them. The Administrator indicated Resident #19 had not been assessed for self-administration of medications.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to provide personal privacy when Nurse #2 left the door to the resident's room open when assessing Resident #1's indwelling urinary catheter. Nurse #2 did not close the curtain when she pulled the resident's gown up and his brief down resulting in the resident being visible from the hallway while he was exposed. This was for 1 of 1 resident observed for privacy (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE]. Diagnoses included obstructive reflux uropathy (a condition where urine flow is blocked in any part of the urinary tract), benign prostate hypertrophy (enlarged prostate) with urinary complications. A physician's order written on 08/26/25 revealed Resident #1 had an order for indwelling urinary catheter and to provide catheter care each shift for urinary retention. The Minimum Data Set quarterly assessment dated [DATE] revealed Resident #1 was severely cognitively impaired and was coded as having an indwelling urinary catheter. An observation of urinary catheter care was conducted with Nurse Aide (NA) #1 on 09/17/25 at 10:20 AM. NA #1 closed Resident #1's door but did not pull the privacy curtain. Resident #1 resided in the bed closest to the door, he had a roommate who was in the room, and the roommate's privacy curtain was pulled closed. Once the catheter care was completed, NA #1 noticed Resident #1's catheter tubing to have bloody urine. NA #1 stated she would let Nurse #2 know. NA #1 left the room and left the door open. An observation was conducted from the hallway outside of Resident #1's room on 09/17/25 at 10:35 AM. Nurse #2 entered the resident's room, applied gloves and proceeded to pull Resident #1's gown up and take down his brief to assess the catheter insertion cite. Nurse #2 did not close the door or pull Resident #1's curtain for privacy. The door was fully opened door and Resident #1 was observed from the hall outside his door exposing Resident #1's bare stomach and penis. Staff were noted to be passing by Resident #1's room while Nurse #2 assessed his indwelling catheter. An interview was conducted with Nurse #2 on 09/17/25 at 10:40 AM. Nurse #2 stated she should have provided the resident privacy before she removed his gown and pulled his brief down. She stated she should have closed the door and pulled the privacy curtain. She stated she was flustered and forgot. An interview was conducted with the Director of Nursing (DON) on 09/17/25 at 3:00 PM. The DON revealed she would have expected the nurse to provide privacy for the resident and not let him be exposed to passersby in the hallway or to his roommate. She stated this was an issue and she would make sure further education was done.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of hypoglycemic medication use for 1 of 18 residents reviewed for accuracy of assessments (Resident #72).Findings included: Resident #72 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus II with long term current use of insulin. Review of Resident #72's physician orders revealed an order dated 8/11/25 for Tresiba flex touch subcutaneous solution 100 unit/millileters (ml) (insulin). Inject 24 units subcutaneously in the morning related to type II Diabetes Mellitus. A second order dated 8/11/25 read: Insulin Aspart injection solution 100 units/ml to be injected per sliding scale subcutaneously three times a day related to type II Diabetes Mellitus. Review of Resident #72's Medication Administration Record (MAR) for August 2025 revealed both orders for insulin were administered daily. Review of Resident #72's admission MDS assessment dated [DATE] indicated the resident received insulin injections 7 of 7 days during the lookback period of 7 days. The MDS assessment was not coded for hypoglycemic (including insulin) medication use in the previous 7 days. In an interview with MDS Nurse #1 on 9/16/25 at 10:10 AM she stated Resident #72's MDS should have been coded for use of hypoglycemic medication during the lookback period. MDS Nurse #1 revealed the error was made due to human oversight. In an interview with the Administrator on 9/16/25 at 10:10 AM, she stated Resident #72's MDS should have been coded correctly, showing the resident received hypoglycemic medication (including insulin).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop and implement a person-centered care plan for a resident who had a diagnosis of Post Traumatic Stress Disorder for 1 of 1 record reviewed for Post Traumatic Stress Disorder (Resident #5). The findings included: Resident #5 was admitted to the facility on [DATE]. Diagnoses included Post Traumatic Stress Disorder (PTSD), delusional disorders, mood disorder, and major depressive disorder. A Trauma Informed Assessment was completed and dated 09/11/24 for Resident #5. The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #5 was cognitively intact and demonstrated no behavior during this assessment period. Review of Resident #5's current care plan revealed there was no plan of care in place for Post Traumatic Stress Disorder. An interview was conducted with Nurse #2 on 09/18/25 at 10:10 AM. Nurse #2 stated she was not aware of any specific triggers Resident #5 had as a result of her PTSD. She stated Resident #5 had some behaviors such as refusal of care, and paranoid behavior and was care planned for those behaviors. Nurse #2 stated if she wanted to know what interventions were in place she would refer to the care plan. An interview with the MDS Nurse on 09/18/25 at 9:50 AM revealed Resident #5 should have had a person-centered care plan for her diagnosis of PTSD. She stated the care plan should identify triggers that would precipitate negative responses or outcomes. She stated Resident #5's post-traumatic stress trigger included loud noises. The MDS Nurse stated she did not put a care plan in place because Resident #5 has not had any problems with her PTSD since admission. An interview with the Director of Nursing on 09/18/25 at 10:15 AM revealed she would have expected a person-centered plan of care be developed for Resident #5 due to her diagnosis of PTSD. The DON stated Resident #5 has not had any identifying triggers or concerns in the time she had been at the facility, but should she have a Post Traumatic Stress episode, staff should be aware of what to do.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop a comprehensive care plan within 7 days of the completion of the comprehensive assessment to include the use of psychotropic medications for 2 of 2 residents reviewed for care planning (Resident #21 and Resident #66). Findings included: 1. Resident #21 was admitted to the facility on [DATE] with diagnoses that included non-Alzheimer's dementia, anxiety and major depressive disorder. Review of Resident #21's admission Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was taking antianxiety and antidepressant medications. The MDS assessment revealed psychotropic medication use and care planning decision was triggered in Care Area Assessment (CAA) section of the MDS. Review of Resident #21's physician orders revealed an order for Fluoxetine hydrochloride (HCL) 40 mg (an antidepressant) give one capsule by mouth in the morning related to major depressive disorder with a start date of 8/22/25. Review of Resident #21's comprehensive care plan created 8/28/25 revealed no care plan regarding psychotropic medication. In an interview with MDS Nurse #1 on 9/16/25 at 10:10 AM she stated Resident #21's care plan should have been created with psychotropic medication use when the admission MDS was coded for antianxiety and antidepressant medication use. MDS Nurse #1 further stated the CAA had been triggered for psychotropic medication use and the care plan was not created at that time due to human error. In an interview with the Director of Nursing (DON) on 9/17/25 at 1:53 PM, she indicated the MDS nurse, or floor nurse were responsible for generating the initial care plan. The DON stated staff discussed new medication orders in morning meeting each day and the MDS nurse or Unit Manager were responsible for updating care plans. She further stated there was not a single person identified as being responsible and that was probably why Resident #21 did not have a care plan for psychotropic medications. In an interview with the Administrator on 9/17/25 at 1:50 PM she stated she thought MDS Nurses were responsible for creating the initial care plan. The Administrator further stated psychotropic medication use should have been care planned for Resident #21. 2. Resident #66 was admitted to the facility on [DATE] with diagnoses that included anxiety, depression and Alzheimer's dementia. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #66 took antianxiety medication. The MDS assessment revealed psychotropic medication use and care planning decision was triggered in Care Area Assessment (CAA) section of the MDS. Review of Resident #66's physician orders revealed and order for Ativan oral tablet 1 milligram (mg) (Lorazepam) (an antianxiety medication) give one tablet by mouth every eight hours as needed for anxiety, agitation for 14 days with a start date of 8/28/25 and an end date of 9/9/25. Review of Resident #66's care plan last revised on 9/2/25 revealed there was no care plan regarding psychotropic medication. In an interview with MDS Nurse #1 on 9/16/25 at 10:10 AM she stated Resident #66's care plan should have been created with psychotropic medication use when the admission MDS was coded for antianxiety medication use. MDS Nurse #1 further stated the CAA was triggered for psychotropic medication use and the care plan was not created at that time due to human error. In an interview with the Director of Nursing (DON) on 9/17/25 at 1:53 PM, she indicated the admitting nurse, MDS nurse, or floor nurse were responsible for updating care plans. The DON stated staff discussed new medication orders in morning meeting each day and the MDS nurse or Unit Manager were responsible for updating care plans. She further stated there was not a single person identified as being responsible for updating care plans after morning meeting, and that was probably why Resident #66 did not have a care plan for psychotropic medications. In an interview with the Administrator on 9/17/25 at 1:50 PM she stated she thought MDS Nurses were responsible for updating care plans. The Administrator further stated psychotropic medication use should have been care planned for Resident #66.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review and staff interviews, the facility failed to secure medications used in the treatment of wounds in an unattended and unlocked treatment cart for 1 of 1 treatment cart observed. The facility further failed to store a medication according to the manufacturers' guidelines for 2 of 3 medication carts observed (400 hall and 200 hall). Findings included: 1. A continuous observation was conducted of the facility treatment cart on 9/16/25 from 8:10 AM to 8:35 AM. The cart was observed to be parked next to the door of the Wound Care Nurse’s office, facing out to the hallway at the end of 200 hall. The treatment cart was observed to be unlocked as evidenced by the push lock not being flush with the cart face as it would have been had it been locked. There was no staff member with the treatment cart, no staff in the Wound Care Nurse's office or in the offices across the hall from the cart. During the observation, two visitors, the Director of Nursing (DON), kitchen manager, nurse supervisor, two staff nurses and two Nurse Aides (NA) walked by the unlocked treatment cart. At 8:15 AM a resident was approximately 3 feet away in her wheelchair. At 8:35 AM the Wound Care Nurse approached the treatment cart and locked it. The Wound Care Nurse was asked what was kept in the treatment cart and she stated it held bandages. During an observation of the contents of the treatment cart with the Wound Care Nurse it was discovered the bottom drawer held several topical medications used to clean and treat wounds including antiseptic solution for skin wounds, medical grade honey, hydrocortisone cream, corticosteroid cream and a cream used to treat skin conditions. The Wound Care Nurse indicated these medications could possibly be dangerous if a cognitively impaired resident were to have access to them. The Wound Care Nurse revealed she had forgotten to lock the treatment cart this morning, and she knew she was to have kept the cart locked at all times when she wasn’t using it. In an interview with the DON on 9/16/25 at 8:44 AM she stated the treatment cart should be locked at all times when not directly in use. The DON indicated the medications kept in the treatment cart could pose a possible danger for a resident were they to ingest them. In an interview with the Administrator on 9/16/25 at 8:50 AM she indicated the treatment cart should have been locked since the Wound Care Nurse was not using the cart. The Administrator stated various topical medications are kept in the treatment cart that could be harmful if ingested by a cognitively impaired resident. 2. Review of the manufacturers’ instructions on the bottle indicated the nasal spray must be stored in an upright position. Storing the bottle in an upright position prevents leaking and ensures the pump mechanism works correctly. a. An observation of the 400-hall medication cart on 09/17/25 at 8:50 AM with Nurse #3 revealed a medication called Astelin nasal spray (a prescription nasal spray used to relieve symptoms of seasonal allergies), was noted to be stored horizontally, not in an upright position, in the medication cart. An interview with Nurse #3 revealed she did not read the manufacturers’ instructions and did not know the medication should be stored in the upright position. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. An observation of the 200-hall medication cart on 09/17/25 with Nurse #4 revealed the Astelin nasal spray was noted to be stored horizontally, not in an upright position, in the medication cart. An interview with Nurse #4 revealed she did not read the manufacturers’ instructions and did not know the medication should be stored in the upright position. An interview with the Director of Nursing (DON) on 09/17/25 at 3:30 PM revealed she would expect her nursing staff to be checking the carts and reading all manufactures’ guidelines for proper medication storage. The DON stated if the bottle indicated the nasal spray needed to be stored upright, then the bottle should be stored upright.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and staff interviews, the facility failed to follow their infection control policy and procedures for Enhanced Barrier Precautions (EHB) during high contact care for a resident with an indwelling urinary catheter, when a nurse aide and a nurse were providing catheter care without wearing personal protective equipment (PPE) to include a gown for 2 of 6 staff observed for infection control practices (Nurse Aide #1 and Nurse #2). Findings included: The facility policy titled, Enhanced Barrier Precautions dated 06/13/2024 stated in part: EBP are used in conjunction with standard precautions to reduce the risk for multi drug resistant organism transmission during high contact resident care activities. Includes the use of both gowns and gloves. High contact resident care activities were listed as: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs and assisting with toileting, device care or use, central lines, urinary catheter, feeding tube, tracheostomy and wound care, any skin opening requiring a dressing. An observation of catheter care was conducted with Nurse Aide (NA) #1 on 09/17/25 at 10:20 AM. Nurse Aide #1 entered Resident #1's room, closed the door, washed her hands and applied gloves that were on the wall located near the door. The PPE to include gowns was noted hanging on the back of the door. Nurse Aide #1 did not apply a gown. Nurse Aide #1 proceeded to lift Resident #1's gown and lowered his brief to access the indwelling urinary catheter. Nurse Aide #1 provided care to catheter but never applied a gown. Nurse Aide #1 noted there was bloody urine in the tubing of the catheter and in the catheter bag and stated she would notify Nurse #2. Nurse Aide #1 secured the brief back on the resident and lowered his gown. She removed her gloves and washed her hands. An interview was conducted with Nurse Aide #1 on 09/17/25 at 10:30 AM. Nurse Aide #1 stated when asked why she did not apply a gown during the catheter care; she stated she was just focusing on getting the care done and forgot to put the gown on. Nurse Aide #1 reviewed the signage on the door for Enhanced Barrier Precautions and stated she should have put a gown on while providing catheter care. An observation was conducted of Nurse #2 assessing Resident #1's indwelling urinary catheter on 09/17/25 at 10:35 AM. Nurse #2 entered Resident #1's room, washed her hands, and applied gloves. Nurse #2 did not apply a gown. Nurse #2 was observed lifting Resident #1's gown and lowering his brief to assess the insertion site of the indwelling catheter. Once she was finished assessing the site, she secured the brief, lowered the gown, and disposed of her gloves and washed her hands. An interview was conducted with Nurse #2 on 09/17/25 at 10:40 AM. Nurse #2 reported she was flustered and forgot to apply a gown. Nurse #2 stated she should have applied a gown since she was assessing the indwelling urinary catheter. An interview with the Staff Development Coordinator (SDC) on 09/17/25 at 10:50 AM. The SDC stated both staff members should have applied a gown while providing care to Resident #1's urinary catheter. The SDC stated both staff members have been educated on the importance and adherence of the Enhanced Barrier Precautions, but she would reinforce the education. An interview with the Director of Nursing (DON) on 09/17/25 at 3:30 PM revealed she would have expected both staff members to apply the appropriate PPE to include gowns whenever providing care to an indwelling urinary catheter. She stated the Enhanced Barrier Precaution policy was in place to protect other residents and staff members from infection.